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california perinatal quality care collaborative

Admission/Discharge Form for Infants Born in 2017

Network ID ☐☐☐☐☐ Hospital ID ☐☐☐☐

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Selection Criteria

To be eligible, you MUST answer YES to at least one of the possible criteria (A-C)

A. 401 – 1500 grams ☐ Yes ☐ No
Yes (Go to item.1, No (Go to Part B)

B. GA range 22 0/7 – 31 6/7 weeks ☐ Yes ☐ No
Yes (Go to item.1, No (Go to Part C)

C. If > 1500 grams ☐ Yes ☐ No

Answer ALL entry criteria. To be eligible, MUST answer YES to at least one:

Note: Any infant that was previously discharged home and re-admitted to any location in our hospital (On or before Day 28) for Total Serum Bilirubin=>25mg/dl (427 Micromols/Liter) and/or exchange transfusion is CPQCC eligible.

Death	☐ Yes	☐ No	Hyperbilirubinemia	☐ Yes	☐ No
Surgery requiring Anesthesia	☐ Yes	☐ No	Acute Transport-In	☐ Yes	☐ No
Intubated Vent >4hrs	☐ Yes	☐ No	Acute Transport-Out	☐ Yes	☐ No
Non-Intubated Vent>4 hrs	☐ Yes	☐ No	Early Bacterial Sepsis	☐ Yes	☐ No
Suspected Encephalopathy or Suspected Perinatal Asphyxia	☐ Yes	☐ No	Active Therapeutic Hypothermia	☐ Yes	☐ No

Any eligible inborn infant who dies in the delivery room or at any other location in your hospital within 12 hours after birth and prior to admission to the NICU is defined as a "Delivery Room Death." These locations may include the mother's room, resuscitation rooms, or any location other than the NICU in your hospital. Outborn infants and infants who are admitted to the NICU should not be classified as Delivery Room Deaths.

The sections **Identification and Demographics, and Delivery and Maternal History** should be filled out when an eligible infant is admitted to your NICU.

The **Post-delivery Diagnoses and Interventions sections** (respiratory, infections, other diagnoses, surgeries, and surgical complications, neurological, and congenital malformations) and the **Initial Disposition section** should be filled out when the baby is discharged for the first time from your center.

The **Transport section** only needs to be filed out if the infant was transported after its initial stay.

IDENTIFICATION AND DEMOGRAPHICS

1. Birth Weight	☐☐☐☐ Grams		
2. Head Circumference at Birth	☐☐.☐ cm		☐ Unk
3. Best estimate of gestational age *(DO NOT leave days blank)*	☐☐ **a) Weeks**	☐ **b) Days (0-6)**	☐ Unk
4a. Birth Date (*MM/DD***)** **4b. Birth Time** (00:00 AM/PM)	☐☐/☐☐ 2017 ☐☐:☐☐ ☐ AM ☐ PM `		
5. Infant Sex	☐ Male	☐ Female	☐ Unk
6. Died in Delivery Room *(If YES, Use DRD Form)*	☐ Yes	☒ No	

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7. a) Location of Birth ☐ Inborn ☐ Outborn ☐ Born at Co-Located Hospital (Satellite NICUs Only)

Note: For infants who were previously home, always check Outborn, even if the infant was born at your hospital or was born at the Co-located hospital (for Satellite NICUs only.)

b) Age in Days at Admission to your NICU ☐☐ Date of Birth is day 1

c) Hospital of birth for Outborn infants ☐☐☐☐☐☐ ☐ Unk ☐ NA

If Outborn, enter Code for Birth Hospital

8. Hospital Admission History (*Answer only for Outborn infants. Answer Parts a) and b)*)

Note: The Hyperbillirubinenia items 50 to 52 are activated ONLY IF the infant Was Home after Brith (Item 8a). A home birth does NOT qualify for checking "Previously Discharged Home from a Hospital after Birth."

a) ☐ Never Discharged Home from a Hospital after Birth ☐ Was Previously Discharged home after Birth ☐NA

b) ☐ First Admission to this NICU ☐ Readmission to this NICU ☐ NA

MATERNAL HISTORY

9. Maternal Date of Birth (MM/DD/YY) ☐☐/☐☐/☐☐ ☐ Unk

Maternal Age ☐☐ Years ☐ Unk

10. Maternal Race/Ethnicity
Answer both Parts a) and b)

a) Is Mother of Hispanic Origin? ☐ Yes ☐ No ☐ Unk

b) Maternal Race *(Choose only one)*

☐ Black ☐ Native Hawaiian/ Pacific Islander ☐ White
☐ Asian ☐ American Indian/ Alaska Native ☐ Other ☐ Unk

11. Prenatal Care ☐ Yes ☐ No ☐ Unk

12. Group B Strep Positive ☐ Yes ☐ No ☐ Not Done ☐ Unk

13. a) Is there documentation that Antenatal Steroids therapy was initiated before delivery?

☐ Yes ☐ No ☐ Unk

b) Is there documentation in the medical record of reasons for NOT initiating antenatal steroid therapy before delivery?

(Starting from 2013, this item is only applicable and OPTIONAL for inborn infants who are <32 weeks gestational age.)

☐ Yes ☐ No ☐ Unk

c) If yes, what was the documented reason for NOT administering antenatal steroids?

(Starting from 2013, this item is only applicable and OPTIONAL for inborn infants who are <32 weeks gestational age.)

☐ Chorioamnionitis
☐ Other active infection
☐ Immediate delivery
☐ Fetus has anomalies incompatible with life
☐ History of adverse reaction to corticosteroids
☐ Comfort care
☐ Other
☐ NA
☐ Unknown

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14. Spontaneous Labor	☐ Yes	☐ No	☐ Unk
15. a) Multiple Gestation	☐ Yes	☐ No	☐ Unk
b) If Yes to multiple gestation, number of infants delivered including stillbirths	☐	☐ Unk	☐ NA
c) Birth Order	☐	☐ Unk	☐ NA

16. Delivery Mode *(Choose only one)* ☐ Spontaneous Vaginal ☐ Operative Vaginal ☐ Cesarean ☐ Unk

17. Antenatal Conditions (*Select all conditions occurring in this pregnancy. If NONE, select the checkbox for "None" in each column***)**

Maternal	☐ None ☐ Hypertension ☐ Chorioamnionitis ☐ Other Infection	☐ Diabetes ☐ Prev. Cesarean ☐ Antenatal Magnesium Sulfate	☐ Other Maternal ☐ Unk ☐ Other *(Specify)*
Fetal	☐ None ☐ IUGR ☐ Distress	☐ Anomaly ☐ Other Fetal ☐ Unk	☐ Other *(Specify)*
Obstetrical	☐ None ☐ Preterm (<37 wks) Labor ☐ Preterm (<37 wks) Premature ROM before onset of labor ☐ Term Premature ROM (≥37 weeks, before onset of labor, not premature gestation) ☐ Prolonged ROM (>18 hrs)	☐ Malpresentation/Breech ☐ Bleeding/Abruption/Previa ☐ Other Obstetrical (describe) ☐ Unk ☐ Other *(Specify)*	

18. Indication for Cesarean Section *(Select at least one)*

☐ Not Applicable (No C/S)	☐ Multiple Gestation	☐ Elective	☐ Placental Problems	☐ Unk
☐ Malpresentation/ Breech	☐ Fetal Distress	☐ Dystocia/Failed to Progress	☐ Hypertension	☐ Other *(Specify)*

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DELIVERY ROOM AND FIRST HOUR AFTER BIRTH

19. a) Apgar Scores

☐☐ 1 Min ☐ Unk ☐☐ 5 Min ☐ Unk ☐☐ 10 Min ☐ Unk ☐ Not Done

b) Suspected Encephalopathy or Suspected Perinatal Asphyxia Low 5-Min and/or 10-Min Apgar Score**.** (Answer only if greater than 1500 grams). (This definition of suspected encephalopathy or suspected perinatal asphyxia is different from the criteria for hypoxic Ischemic encephalopathy (HIE) defined later in item 48 (i.e., not all patients meeting eligibility criteria under suspected encephalopathy or suspected perinatal asphyxia will have HIE according to the HIE definition).

☐ Yes ☐ No ☐ NA ☐ Unk

c) Is there an umbilical cord blood gas or a baby blood gas in the first hour of life available?
(Starting from 2015, only ask if the baby with birthweight greater than 1500grams has any of the following 3 criteria: 1) admitted with suspected encephalopathy or suspected perinatal asphyxia [Yes to item 19b], 2) received active hypothermia [Selective or Whole body to item 22d], or 3) diagnosis with HIE [Yes to item 48].)

☐ Yes ☐ No ☐ NA ☐ Unk

(If yes to item 19b, then ask items 19c, 19d, 19e and 19f.)

c) Source of blood gas

- ☐ Cord umbilical arterial (UA)
- ☐ Cord umbilical venous (UV)
- ☐ Arterial baby gas
- ☐ Venous baby gas
- ☐ Capillary baby gas
- ☐ NA
- ☐ Unk

d) pH within one hour of life ☐ . ☐☐ ☐ NA ☐ Unk

e) Base deficit ☐☐ . ☐ ☐ NA ☐ Unk

20. Delivery Room Resuscitation

a) Oxygen	☐ Yes	☐ No	☐ Unk	**d) Endotracheal Tube/Vent**	☐ Yes	☐ No	☐ Unk
b) CPAP	☐ Yes	☐ No	☐ Unk	**e) Epinephrine**	☐ Yes	☐ No	☐ Unk
				f) Cardiac Compressions	☐ Yes	☐ No	☐ Unk
c) Bag/Mask	☐ Yes	☐ No	☐ Unk	**g) Nasal Intermittent Positive Pressure**	☐ Yes	☐ No	☐ Unk

21. Surfactant Use

a) Was Surfactant given in the Delivery Room? ☐ Yes ☐ No ☐ Unk

b) Was Surfactant given at any time? ☐ Yes ☐ No ☐ Unk

c) Enter age at first dose: ☐☐ Hrs ☐☐ Min ☐ Unk ☐ NA

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POST-DELIVERY DIAGNOSES AND INTERVENTIONS—RESPIRATORY

22. Temperature and Cooling for HIE

a) Was the temperature measured within one hour of NICU admission?

☐ Yes ☐ No ☐ Unk

b) Enter first temperature either in Centigrade or Fahrenheit Degrees:

☐☐.☐ ☐ Too Low to Register ☐ NA ☐ Unk

Note: The temperature has to be entered even if the infant continued cooling in your NICU or started cooling in your NICU prior to the first temperature.

c) Infant cooling status during stay at your NICU

☐ No Cooling for HIE ☐ Cooling Started for HIE ☐ Cooling Continued for Transport-In for HIE ☐ Unk

d) Cooling Method for HIE

☐ Passive ☐ Selective Head ☐ Whole Body ☐ Other ☐ Unk

23. Respiratory Support After Leaving Delivery Room

a) Oxygen	☐ Yes	☐ No	☐ Unk	
b) Intubated Conventional Ventilation	☐ Yes	☐ No	☐ Unk	
c) Intubated HIFI Ventilation	☐ Yes	☐ No	☐ Unk	
d) High Flow Nasal Cannula	☐ Yes	☐ No	☐ Unk	
e) Nasal IMV or SIMV (or any other form of non-intubated assisted ventilation)	☐ None	☐ ≤ 4 hours	☐ > 4 hours	☐ Unk

24. Use of Nasal CPAP

a) Nasal CPAP	☐ Yes	☐ No	☐ Unk	
b) If yes to either 20b or 24a, was NCPAP first used before any ETT Ventilation?	☐ Yes	☐ No	☐ Unk	☐ NA

Note: If ETT ventilation was never used, check Yes.

25. Use of Intubated Assisted Ventilation

a) Length of Intubated Assisted Ventilation ☐ None ☐ ≤ 4 hours ☐ > 4 hours ☐ Unk

b) If Intubated Ventilation > 4 hours, specify ventilation time in Days: ☐☐☐ Days ☐☐ Hours (0-23)

If you prefer to enter the total number of hours, the infant was ventilated in your NICU, enter total number of hours ventilated: ☐ Hours

Note: The total number of hours ventilated is NOT transmitted to the CPQCC database.

26. Infant Death within 12 Hours of NICU Admission	☐ Yes	☐ No	☐ Unk		
27. Respiratory Distress Syndrome	☐ Yes	☐ No	☐ Unk		
28. Pneumothorax	☐ Yes, here	☐ Yes, elsewhere	☐ Yes, here & elsewhere	☐ No	☐ Unk
29. Meconium Aspiration Syndrome	☐ Yes	☐ No	☐ Unk		

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30. Inhaled Nitric Oxide ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ Unk

31. ECMO ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ Unk

32. Postnatal Steroids

a) Were postnatal steroids used? ☐ Yes ☐ No ☐ Unk

b) If postnatal steroids were used, check all reasons that applied

☐ Chronic Lung Disease (**check location**): ☐ Given here ☐ Given elsewhere ☐ Given here and elsewhere

☐ Extubation ☐ Hypotension/ Blood Pressure ☐ Other reason ☐ Unk ☐ NA

33. Supplemental Oxygen on Day 28

Based on birth date and provided, the date of day 28 is [use www.cpqccdata.org CALCULATOR TOOL).

☐ Continuous ☐ Intermittent ☐ None ☐ NA ☐ Unk

34. Respiratory Support at 36 Weeks Adjusted Gestational Age

Based on birth date and gestational age provided, the date of the first day of week 36 is [use www.cpqccdata.org CALCULATOR TOOL). To find the Date of Week 36, add the number of days needed to reach 36 Weeks, 0 Days to the infant's gestational age at birth. A chart showing the Date of Week 36 for infants born in 2017 may be downloaded from www.vtoxford.org/downloads.

a) Supplemental Oxygen at 36 Weeks Adjusted Gestational Age	☐ Continuous	☐ Intermittent	☐ None	☐ NA	☐ Unk
b) Intubated Conventional Ventilation at 36 Weeks Adjusted Gestational Age	☐ Yes	☐ No	☐ NA	☐ Unk	
c) High Frequency Ventilation at 36 Weeks Adjusted Gestational Age	☐ Yes	☐ No	☐ NA	☐ Unk	
d) High Flow Nasal Cannula at 36 Weeks Adjusted Gestational Age	☐ Yes	☐ No	☐ NA	☐ Unk	
e) Nasal IMV or SIMV at 36 Weeks Adjusted Gestational Age	☐ Yes	☐ No	☐ NA	☐ Unk	
f) Nasal CPAP at 36 Weeks Adjusted Gestational Age	☐ Yes	☐ No	☐ NA	☐ Unk	

35. Respiratory Support at Discharge

(Note: Responses to this item will be ignored if you do not answer item 54, initial disposition from your center)

a) Apnea/Cardio-Respiratory Monitor	☐ Yes	☐ No	☐ Unk
b) Oxygen	☐ Yes	☐ No	☐ Unk
c) Intubated Mechanical Ventilation	☐ Yes	☐ No	☐ Unk
d) Other Device	☐ Yes	☐ No	☐ Unk

If Yes, specify: ________________________________

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POST-DELIVERY DIAGNOSIS AND INTERVENTIONS—INFECTIONS

36. Early Bacterial Sepsis and/or Meningitis on or before Day 3 *(Based on the birth date provided, the date of day 3 is*

[use www.cpqccdata.org CALCULATOR TOOL).

☐ GBS ☐ e.Coli ☐ Other, specify organism: ________________ ☐ No ☐ Unk

37. Late Sepsis and/or Meningitis after Day 3 *(Based on the birth date provided, the date of day 3 is*

[Use www.cpqccdata.org calculator tool]

a) Bacterial Pathogen

☐ GBS ☐ e.Coli ☐ Other, specify organism: ________________ ☐ No ☐ NA ☐ Unk

If GBS, e.Coli, or Other, check location of occurrence: ☐ Here ☐ Elsewhere ☐ Here and Elsewhere

b) Coagulase Negative Staphylococci

☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ NA ☐ Unk

c) Fungal

☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here and elsewhere ☐ No ☐ NA ☐ Unk

38. Congenital Viral Infection: ☐ Yes, specify pathogen: ________________ ☐ NA ☐ Unk

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – OTHER DIAGNOSES, SURGERIES, AND SURGICAL COMPLICATIONS

39. a) Patent Ductus Arteriosus

☐ PDA meeting revised 2012 VON definition

☐ PDA diagnosis based on echo and/or clinical evidence or was treated for PDA, but not meeting all 2012 VON criteria

☐ No

☐ Unk

b) Indomethacin for Any Reason ☐ Yes ☐ No ☐ Unk

c) Ibuprofen for PDA ☐ Yes ☐ No ☐ NA ☐ Unk

d) PDA Ligation ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ NA ☐ Unk

e) PDA Closure by Catheterization ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ Unk

40. a) Probiotic ☐ Yes ☐ No ☐ Unk

b) Necrotizing Enterocolitis ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ NA ☐ Unk

c) NEC Surgery ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ NA ☐ Unk

41. Focal Intestinal Perforation ☐ Yes, here ☐ Yes, elsewhere ☐ Yes, here & elsewhere ☐ No ☐ NA ☐ Unk

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42. Retinopathy of Prematurity

Note: Starting from 2013, this section is only applicable to infants 401 to 1,500 grams or 22 to 31 completed weeks of gestation.

a) Was a retinal exam performed?	☐ Yes	☐ No	☐ NA	☐ Unk		
b) If retinal exam was performed, enter worst stage of ROP (0-5)		☐	☐ NA	☐ Unk		
c) Treatment of ROP with Anti-VEGF Drug	☐ Yes	☐ No	☐ NA	☐ Unk		
d) ROP Surgery	☐ Yes, here	☐ Yes, elsewhere	☐ Yes, here & elsewhere	☐ No	☐ NA	☐ Unk

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43. a) Other Surgery ☐ Yes ☐ No ☐ Unk

b) If Yes, enter up to 10 surgery codes ☐☐☐☐☐☐☐☐☐☐

Enter surgery description for codes S100, S200, S300, S400, S500, S600, S700, S800, S900, S1000

☐

~~44. Surgical Complications.)~~

POST-DELIVERY DIAGNOSES AND INTERVENTION – NEUROLOGICAL

45. Intracranial Hemorrhage *(Based on the birth date provided, the date of day 28 is [use www.cpqccdata.org CALCULATOR TOOL).*

a) Neural imaging done on or before Day 28 ☐ Yes ☐ No ☐ Unk

b) If neural imaging was done on or before Day 28, enter worst grade of peri-intraventricular hemorrhage: ☐ ☐ Unk

c) If peri-intraventricular hemorrhage (PIH) was present, where was it first diagnosed?

☐ First Here ☐ First Elsewhere ☐ NA ☐ Unk

d) If PIH present, was shunt placed for bleed? ☐ Yes ☐ No ☐ NA ☐ Unk

e) If neural imaging was done on or before Day 28, was any other Intracranial Hemorrhage found?

☐ Yes, describe: ______________________________ ☐ No ☐ NA ☐ Unk

46. Cystic Periventricular Leukomalacia (CPVL)

a) Was a neural image done? ☐ Yes ☐ No ☐ Unk

b) If Yes to a), evidence of Cystic PVL? ☐ Yes ☐ No ☐ NA ☐ Unk

47. Seizures, EEG or Clinical ☐ Yes ☐ No ☐ Unk

48. Hypoxic-Ischemic Encephalopathy *(This item is not applicable if this infant was less than 36 weeks of gestation at birth)*

Note: This definition of hypoxic ischemic encephalopathy (HIE) is different from eligibility criteria of entry into database for encephalopathy or perinatal asphyxia (i.e., not all patients meeting eligibility criteria under encephalopathy or perinatal asphyxia will have HIE according to the HIE definition.

☐ None ☐ Severe ☐ Moderate ☐ Mild ☐ NA ☐ Unk

POST-DELIVERY DIAGNOSES AND INTERVENTIONS – CONGENITAL MALFORMATIONS

49. a) Congenital anomalies ☐ Yes ☐ No ☐ Unk

b) Enter up to 5 birth defect codes: ☐☐☐☐☐

Enter birth defect description for codes 100 150 200 300 400 504 601 605 800 900:

____

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POST-DELIVERY DIAGNOSES AND INTERVENTIONS – HYPERBILIRUBINEMIA

Note: The following items 50 to 52 pertain to ANY infant that was previously discharged home and re-admitted before day 28.

50. Maximum Level of Bilirubin (mg/dl) Found On THIS Re-Admission

☐ <25 ☐ 25 - <30 ☐ ≥30 ☐ NA ☐ Unk/Not Done

51. Exchange Transfusion On THIS Re-Admission

☐ Yes ☐ No ☐ NA ☐ Unk

52. Hospital that Discharged Infant Home Prior to THIS Admission *(Note: Enter OSHPD Code. See manual for OSHPD Codes)*

☐☐☐☐☐☐ ☐ NA ☐ Unk

Name of Facility: ______________________________

INITIAL DISPOSITION

Note: Responses in this section will be ignored if you do not answer item 54, initial disposition from your center!

53. Enteral feeding at Discharge

☐ None ☐ Human Milk Only ☐ Human Millk with Fortifier or Formula ☐ Formula Only ☐ Unk

54. Initial Disposition from our center

☐ Home ☐ Died ☐ Transported ☐ Still Hospitalized as of 1st Birthday ☐ Unk

55. Weight at Initial Disposition ☐☐☐☐☐ Grams ☐ Unk

56. Head Circumference at Initial Disposition (cm) ☐☐.☐ cm ☐ Unk

57. Initial Discharge Date
(The initial length of stay for this infant is __ days)
[Use www.cpqccdata.org Calculator tool]

☐☐/☐☐/20☐☐ (M M / D D / Y Y) ☐ Unk

TRANSPORT INFORMATION

Note: If infant was transported to another hospital, complete items 58-60.

58. Reason for Transport

☐ ECMO ☐ Growth/Discharge Planning ☐ Medical/Diagnostic Services ☐ Surgery ☐ Chronic Care
☐ Insurance ☐ Other Reason ☐ NA ☐ Unk

59. Hospital the infant was transported to: *(Note: Enter OSHPD Code. See manual for OSHPD Codes)*

☐☐☐☐☐☐ ☐ NA ☐ Unk

Name of Facility: ______________________________

60. Post-Transport Disposition

☐ Home – Skip to Question 64
☐ Transported again to another hospital – Skip to Question 63
☐ Died – Skip to Question 64
☐ Re-admitted to your hospital – Continue with Question 61
☐ Still hospitalized as of 1st birthday – Skip to Question 64
☐ NA
☐ Unk

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california perinatal
quality care collaborative

Admission/Discharge Form for Infants Born in 2017

Network ID ☐☐☐☐☐ Hospital ID ☐☐☐☐

Please DO NOT mail or fax this form to the CPQCC Data Center. This form is for internal use ONLY.

Complete items 61-62 for infants who were initially transported from your center and then transported back to your center without ever going home.

For these infants, it is necessary to update items 21, 23-25, 27-53 with information that should be obtained from the episode of care at the hospital the infant was transported to and the care upon re-admission to your center.

Note that these items do not need to be tracked for subsequent transports and re-admissions.

61. Weight at Disposition after Re-Admission ☐☐☐☐☐ Grams ☐ NA ☐ Unk

62. Disposition after Re-Admission

☐ Home – Skip to Question 64
☐ Transported again to another hospital
☐ Died – Skip to Question 64
☐ Still hospitalized as of 1st birthday – Skip to Question 64
☐ NA
☐ Unk

Complete item 63 for infants who were initially transported from your center and then a) either transported again to another hospital, or b) re-admitted to your center and then transported from hospital to another hospital.

63. Ultimate disposition

☐ Home ☐ Died ☐ Still hospitalized as of 1st birthday ☐ NA ☐ Unk

64. Last Discharge Date ☐☐/☐☐/20☐☐ (M M / D D / Y Y) ☐ NA ☐ Unk

Notes:

Sections of this form includes data elements and definitions developed by Vermont Oxford Network
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